

with mild crusting. There was no generalised lymphadenopathy. CVS, CNS, abdomen, ocular and genital systems were normal.

Blood VDRL titre was $\frac{1}{64}$ and blood TPHA was positive. Tests for HIV, slit smear test for *Mycobacterium leprae* were negative. Radiographic and CSF examinations were normal. Histopathological examination confirmed the diagnosis. *Treponema pallidum* was demonstrated from the lesions by darkfield microscopy. Her parents were normal. Her contact could not be traced.

She responded to antisyphilitic treatment well within 2 weeks. On follow up, she was clinically and serologically normal.

Malignant syphilis was observed during the great epidemic at the dawn of 16th century. Reports by Sehgal & Rege,¹ Yarovsky & Kholin,¹ Buck,¹ and Lejman & Starzycki,¹ show that it is an uncommon presentation of secondary syphilis today.

Abundant, symmetrical, large papulonodular syphilides all over the body and 2 ulcerative lesions with mild crusting present one in each leg in the early secondary phase without any history or relapse noticed in a 19 year old female differ from the description in the literature of few lesions, usually on the face and scalp in the late secondary or relapse or in early tertiary states.^{2,3}

Weakening of a patient's immunobiological resistance due to various detrimental influences are believed to play a role in the pathogenesis of malignant syphilis.⁴ The absence of any systemic diseases in our case suggested the role of secondary reversible defective cell mediated immunity in secondary syphilis, though this could not be confirmed for lack of facility.

Historical, serological, histopathological evidences and prompt therapeutic response con-

firmed the diagnosis of this early phase of secondary syphilis.

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An increase in pharyngeal gonorrhoea: cause for concern regarding HIV infection

With the exception of 1985, there was a decline in laboratory reports of male rectal gonorrhoea in England and Wales between 1981 and 1989. In 1990 however, there was a four-fold increase compared with 1989; a large proportion, but not all this increase centred in one London clinic. KC60 data for new cases of gonorrhoea (excluding pelvic inflammatory disease) at genitourinary medicine clinics in England and Wales showed an increase in attendance rates of 7.5% for males and 6.2% for females compared with 1989. This was the first increase in cases of gonorrhoea for sixteen years and continued into 1990 in males.¹ The proportion of homosexually acquired infection doubled between the first quarters of 1989 and 1990, and there have been several reports of recent increases in rectal gonorrhoea in homosexual men.²⁻⁴

In Newcastle we have seen a different pattern of infection emerging (see table). Total cases of gonorrhoea have fallen steadily over the last few years. There was a rise in 1991 in homosexually acquired gonorrhoea but the proportion with rectal infection has fallen from 43% in 1990 to 20% last year. Pharyngeal gonorrhoea however has increased markedly in homosexual men, occurring in 55% in 1991, as opposed to 29% in 1990. The throat was the solitary site of infection in 64% in 1991.

These data may reflect a change in sexual behaviour in homosexual men attending our clinic. The increase in cases of gonorrhoea seen in this group last year can be accounted for by the increase in pharyngeal infection. Information leaflets about safer sex stress the risks of HIV transmission through unprotected anal intercourse, while the risk of HIV infection by oral sex is stated to be very low. Dr Murray and colleagues reported a case of coincident acqui-

Fig Numerous papulomodular and two ulcerative syphilides on the lower limbs.



Table Gonorrhoea in Newcastle 1987-1991

	Total gonorrhoea		Gonorrhoea in homo/bisexual men		
	All sites	Pharynx	All sites	Pharynx	Rectum
1987	387	21	18	5	7
1988	268	19	16	2	6
1989	205	17	12	5	4
1990	178	12	14	4	6
1991	155	20	20	11	4

sition of pharyngeal gonorrhoea and HIV from fellatio,⁵ and a study from Amsterdam has shown that between four and nine of 102 homosexual men acquired HIV through orogenital sex.⁶ We are concerned that the number of cases of HIV infection transmitted by oral sex alone will increase in the light of our findings. We need to emphasise to the voluntary sector and the public that there is a real risk of transmission of HIV through oral sex and that the use of condoms is advised.

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Screening for asymptomatic *Chlamydia trachomatis* infection in adolescent men by examination of voided urine

Detection of *Chlamydia trachomatis* (CT) in voided urine with enzyme immunoassay (EIA)^{1,2} opened possibilities for noninvasive screening of asymptomatic infections. Sensitivity and specificity of direct detection of CT with EIA in urine, compared with cultivation from the urethra, was evaluated in several studies and found to be in the range 59-100% and 93-99.3% respectively.^{3,4} In our study the sensitivity and specificity of IDEIA-III test in urine from asymptomatic men visiting the STD clinic was 75% and 96.8% respectively.⁵ These data seem to be acceptable^{4,6} for routine screening of asymptomatic adolescent men.

We performed a study on 547 asymptomatic military recruits (group A) and on 71 adolescent men (group B) attending the youth consultation centre. The average age was 20.2 and 18.0 years respectively. Ten ml of first catch urine was collected and sent chilled to the laboratory. Antigen detection was performed with IDEIA-III (Novo Bio Labs) enzyme immunoassay according to manufacturers instructions. Positive samples and samples in grey-zone (cut-off $\pm 20\%$) were verified with FITC monoclonal antibodies (SYVA Direct Specimen test). The samples that were reactive in EIA and positive in the verification test were considered as truly positive.

Contact tracing for partners of CT infected men was performed according to existing legislation.

The results of the screening of military recruits is summarised in the table. Twenty two

Table Result of screening for asymptomatic *Chlamydia trachomatis* infection in military recruits

Age (Years)	N	EIA reactive	
		Verified positive N	Verified negative N
18	3	0	0
19	151	1*	1*
20	240	9	4 (from which 1*)
21	121	3	1*
22	13	1	1*
>23	19	0	1*
Total	547	14	8

*New urine sample taken for EIA detection—negative result.

urine samples from 547 recruits were reactive in EIA; however, only 14 of these 22 samples were positive even in the verification test (truly positive). Thus prevalence of asymptomatic CT carriers was 2.6%. From five of the recruits with negative verification test results new urine samples were examined, this time with a negative outcome.

Not one of the recruits complained of urethritis symptoms. However, urine deposit of one of the 14 truly positive recruits was very rich in leucocytes; medical examination of this patient revealed nongonococcal urethritis with discharge.

Through contact tracing of the 14 truly positive recruits 17 female sexual partners were identified and medically examined. Five women had signs of genitourinary infection and were given antibiotic treatment for CT infection without laboratory testing. Urethra and cervical samples from twelve contacts were examined in the laboratory and seven women were found CT infected. Thus the prevalence of laboratory verified CT infection in the contact group was 58.3%.

In group B urine samples were obtained from 71 adolescent asymptomatic men. Thirteen samples were EIA reactive and all of them were also positive in the verification test, (prevalence 18.3%). From 16 identified female sexual contacts twelve partners were found positive (prevalence 75%).

Thus screening of 547 recruits in group A and 71 men in group B detected 21 and 25 CT infected persons respectively.

The sensitivity of IDEIA-III in urine specimens from asymptomatic men was estimated to be 75%; thus after correction the real prevalence numbers of group A and B would be 3.9% and 24.4%. The low prevalence in military recruits may reflect the fact that approximately 50% of them had either not experienced sexual intercourse or indicated contact with only one partner.

High prevalence in group B corresponds with the prevalence of asymptomatic patients attending the STD clinic,⁵ while in contrast to the recruit group the majority of these men had already begun sexual activity.

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